Specialty Hospital
Policy Reviewed: Biennially
Person Responsible: Director of Revenue Cycle Management
Chief Financial Officer Approval: 5/30/2024
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SOM Appendix A: A-0117

FINANCIAL ASSISTANCE

Policy Statement

LifeScape's mission is to provide excellence in person-centered services for individuals with special health care and education needs. As part of that commitment, LifeScape appropriately serves patients in difficult financial circumstances and offers financial assistance to those who have an established need to receive medically necessary medical services.

Charity care is defined as healthcare services provided at no charge or at a reduced charge to patients who do not have nor cannot obtain adequate financial resources or other means to pay for their care. This is in contrast to bad debt, which is defined as patient and/or guarantor who, having the financial resources to pay for health care services, has demonstrated by their actions an unwillingness to resolve a bill. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account race, creed, gender, national origin, disability, age, social immigrant status, or sexual orientation.

To establish policies and procedures necessary to ensure patients of LifeScape, who for economic and financial reasons cannot meet the requirements of the collection policy, are provided with the LifeScape's Financial Assistance Policy.

For the purpose of this policy, terms below are defined as follows:

Charity Care: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from the organization's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to the Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

1. Includes earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and miscellaneous sources.
2. Non-cash benefits (such as food stamps and housing subsidies) do not count.
3. Determined on a before-tax basis.

4. Excludes capital gains or losses; and,
5. If a person lives with a family, includes the income of all family members (non-relatives, such as housemates, do not count).

Uninsured: The patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Medically Necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Procedure

For purposes of this policy, "charity" or "financial assistance" refers to healthcare services provided by LifeScape without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity.

1. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual.
2. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and,
3. Medically necessary services, evaluated on a case-by-case basis at LifeScape.

Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social immigrant status, sexual orientation, or creed. LifeScape shall determine whether or not patients are eligible to receive charity for deductibles, co-insurance, or co-payment responsibilities.

Basis for Calculating the Amounts Charged to Patients

The amount that a patient is expected to pay, and the amount of financial assistance offered depends on the patient's insurance coverage and income and assets as set forth in the eligibility section of this Policy. The Federal Income Poverty Guidelines will be used in determining the amount of the write off and the amount charged to patients, if any, after an adjustment.

Amounts charged for emergency and medically necessary medical services to patients eligible for Financial Assistance will not be more than the amount generally billed to individuals with insurance covering such care. LifeScape utilizes the look back method based on claims allowed by Medicare

Fee for Service and all private health insurances that pay claims to the hospital facility during a prior 12-month period. LifeScape will provide an itemized statement to the patient showing the charges and the discount amount applied to the patient's account. The discount will be applied once the patient has submitted a complete application for financial assistance.

Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may:

1. Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial, and other information and documentation relevant to making a determination of financial need; Information collection from the application will include:
    a) Name, address, date of birth, and social security number of applicant and spouse
    b) Marital status
    c) Over 65, blind or Permanently Disabled, and date of disability determination
    d) Employer information, including position and years employed; if less than 3 years name of former employer
    e) Health Insurance Provider, including group number and insured subscriber number. Medicare number and Medicaid number
    f) Monthly Household Income including:
        - Employment (Gross/Net Pay)
        - Part-Time Jobs (Gross/Net Pay)
        - Social Security/Disability
        - Veteran Pension
        - Retirement (all sources)
        - Unemployment Compensation
        - Workers Compensation
        - Union Benefits
        - Inheritance
        - Alimony/Child Support
        - Savings Interest Income
        - Investment Income
    g) Assets
        - Cash on hand/Bank/Savings
        - Investments/CD's (Market value)
        - Loan/Cash value of Life Insurance
        - Residence:
            - Estimated Value
        - Vehicle: Year/Model (Primary and Secondary Vehicles)
        - Farm Real Estate: number of acres
        - Farm Equipment
        - Livestock

- Rental Property
- Business
- Inheritance/Settlement Pending
- Other Assets

h) Monthly Household Expenses
- Rent/Mortgage
- Food
- Utilities
- Car Payments
- Child Care
- Medical/Dental
- Insurance (car, medical, etc.,)
- Other (List Each)

i) Liabilities
- All Medical Bills
- All Credit Cards
- Home Loan
- Vehicle Loan (Primary and Secondary Vehicles)
- Real Estate Loan
- Amount owed on Farm Equipment
- Amount owed on Livestock
- Loan on Rental Property
- Loan on Business

j) Banking Name (List All)
- Checking Account Number and Balance
- Savings Account Number and Balance

k) Name, Address and Phone Number of Contract/Mortgage Holder
l) Name, Address and Phone Number of Landlord

2. Take into account if insurance was offered from employer.
3. Take into account if employer denied health insurance coverage.
4. Take into account eligibility for COBRA benefits.
5. Take into account if application for Medicaid or other government assistance program.
6. Include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring).
7. Include reasonable efforts by LifeScape to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs.
8. Take into account the patient's available assets, and all other financial resources available to the patient; and,
9. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

10. The patient is required to submit documentation of their financial status. The patient must submit a completed Financial Assistance Application.
    a) As a minimum requirement, the patient must furnish a copy of last year's tax return, last three month's income, or a bank statement for proof of income, checking, and savings account balances and investment account balances.
11. Accounts eligible for Charity Care are to be addressed within 240 days of first bill.

It is preferred but not required that a request for charity and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a year prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known.

LifeScape's values of respect and human dignity shall be reflected in the application process, financial need determination and granting of charity. Requests for charity shall be processed promptly and LifeScape shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, LifeScape could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs.
2. Homeless or received care from a homeless clinic.
3. Participation in Women, Infants and Children programs (WIC).
4. Food stamp eligibility.
5. Subsidized school lunch program eligibility.
6. Eligibility for other state or local assistance program that are unfunded (e.g., Medicaid spend-down);
7. Low income/subsidized housing is provided as a valid address; and,
8. Patient is deceased with no known estate.

Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. The basis for the amounts LifeScape will charge patients qualifying for financial assistance is as follows:

1. Patients whose family income is at or below 100% of the FPL are eligible to receive free care.
2. Patients whose family income is over 100% and below 151% of the FPL are eligible to receive a 50% discount.
3. Patients whose family income is over 150% and below 175% of the FPL would be eligible for a 25% discount.
4. Patients whose family income exceeds 175% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of LifeScape; however, the discounted rates shall not be greater than the amounts generally billed commercially insured patients. Once the patient has been deemed eligible, LifeScape will apply the FAP discount to the patient's account.

Notification about charity care available from LifeScape which shall include a contact number shall be disseminated by LifeScape by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in Admitting and Registration departments and the hospital Business Offices. LifeScape also shall publish and widely publicize a summary of this charity care policy on the facility website and in brochures available in-patient access sites. Such notices and summary information shall be provided in the primary language spoken and any other language spoken by 10% of the community population serviced by LifeScape.

LifeScape's management shall develop policies and procedures for internal and external collection practices (including actions the hospital may take in the event of nonpayment, including collections action and reporting to credit agencies) that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from LifeScape, and a patient's good faith effort to comply with his or her payment agreements with LifeScape. For patients who qualify for charity and who are cooperating in good faith to resolve their discounted hospital bills, LifeScape may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts. LifeScape will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:

1. Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by the hospital.
2. Documentation that LifeScape has or has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and that the patient has not complied with the hospital's application requirements.
3. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

In implementing this policy, LifeScape's management shall comply with all other federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

Form

Financial Assistant Application (located on the LINK and LifeScape Website)

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LifeScape
Creating Pathways. Improving Lives.

FINANCIAL ASSISTANCE APPLICATION
Required Documentation Checklist

Please use this form to assist you in returning the items below, as they apply to your situation. These items are required to process your application for financial assistance.

Please note that your application will be denied if all required documentation is not supplied. Please refrain from using correction fluids.

_____ Federal Income Tax Return (1040, W2, and all schedules that apply).

_____ Pay stubs for a period of 13 weeks prior to date of service. (_____ to _____)

_____ Letter of Support, if you have zero income (Attachment B.)

_____ Unemployment Benefits: Either the check stubs for 13 weeks or loops printout.

_____ VA Pension Benefits Letter for the year prior to your visit.

_____ Social Security Benefits Letter for the year prior to your visit.

_____ Child Support and/or Alimony documentation.
If through the Probation Office, please supply the Child Support or Alimony Case #: _____

_____ General Assistance: Copy of your Medicaid card, letter from your case worker stating when you started receiving, amount, and if the case is still open. (Note: This letter can be provided to you if you need to take to your case worker.

_____ Bank Statements (checking and/or savings) the month of your visit which must reflect a balance on the date of your service.

_____ All assets, which include 401k, stock, bonds, IRA, and real estate other than your primary residence.

_____ One form of identification for all immediate family members that are listed on this application (Example: driver license, birth certificate, or social security card.)

_____ A copy of all insurance cards.

_____ Proof of residency on the date of your service (example: driver license, lease, utility bill, rent receipt, etc.) Your name and address must appear on this document.

_____ Self-employed patient: Please provide a profit & loss statement for the three months prior to your visit. This must be completed by an accountant or local tax service.

_____ Other Required Info: _____

Contact Information for Support and Assistance

To speak with someone in the billing department regarding Financial Assistance, please call any of the phone numbers below:

Name	Phone Number	Email Address
Amy Jensen	(605) 444-9711	amy.jensen@lifescapesd.org
Lisa Amundson	(605) 444-9723	lisa.amundson@lifescapesd.org
General Phone Line	(605) 444-9700	Fax: (605) 444-9706

Completed applications can be faxed or mailed.

Our mailing address is:
LifeScape Rehabilitation Center
Attn: Lisa Amundson
1020 W 18th Street
Sioux Falls SD 57104

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APPLICATION FOR PARTICIPATION

Proof of Identification, Income and Assets must accompany this application. Send copies of all requested documents.

*Do **not** send original documents, as they will not be returned.*

SECTION I – Personal Information

Patient Name (Last, First, MI)			
Street Address			
City, State, Zip Code			
Telephone Number			
Date of Application		Social Security Number:	- -
Date of Service		Requested Date of Service:	
Name of Guarantor	(If other than patient)		Family Size**:

SECTION II – Assets Criteria

Individual Assets		
Family Assets		
Assets Include		
	Cash	
	Savings Account	
	Checking Accounts (Bank or Credit Union)	
	Certificates of Deposit (CD's)/IRA/401k	

	Equity in Real Estate (Other than Primary)	
	Other Assets (Treasury Bills, Negotiable Paper, Corporate Stocks/Bonds)	
Total		

**Family size includes self, spouse, and any minor children. A pregnant woman is counted as two.

SECTION III – Income Criteria

When determining eligibility for hospital care assistance, a spouse's income and assets must be used for an adult; parent(s) income and assets must be used for a minor child.

*Proof of Income and Assets **must** accompany this application.*

Income is based on the calculation of twelve months, three months, or one month of income prior to the date of service (whichever is to the applicants' benefit.)

Patient / Family gross Income equals the lesser of the following:

The Last 12 Months	OR	Last 3 Months x 4	OR	Last 3 Months x 12

Sources of Income

	Weekly	**Monthly**	**Yearly**
Salary/Wages before deduction			
Public Assistance			
Social Security Benefits			
Unemployment/Workers Compensation			
Veterans Benefits			
Alimony/Child Support			
Other Monetary Support			
Pension Payments			
Dividends/Interest			
Rental Income			
Net Business Income (Self Employed needs independent verification.)			
Other (Strike benefits, training stipends, military family allotment, income from Estates and Trusts.)			
TOTAL			

SECTION IV – Certification by Applicant

I understand the information which I submit is subject to verification by the appropriate health care facility and the Federal or State Governments. Willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties.

If so requested by the health care facility, I will apply for governmental or private medical assistance for payment of the bill.

I certify the above information regarding my family size, income, and assets is true and correct.

I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets.

Signature of Patient or Guarantor _____ Date _____

LIFESCAPE MEDICAL CENTER FINANCIAL QUESTIONNAIRE

I. ASSETS

Bank Name		Branch Location	
Checking Account #		Balance	
Savings Account #		Balance	
Other Assets:		Balance	
		Balance	
		Balance	
		Total Assets	

II. TOTAL NUMBER OF DEPENDENTS (including yourself) _____

Dependent's Name	Date of Birth	Social Security Number

Please answer the following questions:

Is this service due to a work or Auto related injury?	No	Yes	
Are you currently pending S.S.I.?	No	Yes	Date Filed: _____
Is there litigation pending?	No	Yes	

I understand the information which I submit is subject to verification by LifeScape and Federal and State governments. Willful misrepresentation of these facts will make me liable for all hospital charges. If so requested by LifeScape, I will apply for government or private assistance for the payment of this hospital bill. I further understand that LifeScape will conduct a credit check with Credit Bureau Associates in order to assist in determining my ability to pay.

I certify that the above information regarding my family size, income, and assets is true and correct.

_____ _____
Patient/Guarantor Signature Date

_____ _____
Spouse/Power of Attorney Date
(Documentation needed)

To whom it may concern:

I/We do hereby authorize and request the disclosure of LifeScape, their agent, representative or bearer to inspect, review, copy including Photostat copies of all records pertaining to my age, residence, citizenship, employment, income, resources, health records, and any Social Security Benefits. It is understood that the information obtained be used for purposes directly related to my eligibility for Charity Care.

Photostat copies of this authorization will be considered as valid as the original.

_____ _____
Patient/Guarantor Signature Date

Hospital Assistance is free or reduced charge care and is provided to patients who receive either inpatient or outpatient services. Hospital assistance and reduced charge care is available only for necessary hospital care and does not cover physicians or prescription drugs.

_____ _____
Patient/Guarantor Signature Date

To Whom It May Concern;

I, _____ attest that I provide(d) the necessary room, board, and other life essentials

for _____ at my residence
_____

_____
_____

from ____/____/____to ____/____/____or present. (Please indicate which.)

My relationship to the above patient(s) is that of:
_____

I understand that signing this does not make me financially responsible for any debt and that this form only establishes support.

_____ _____
Patient/Guarantor Signature Date

Telephone Number: ( ) _____

Please note: The person signing this attestation must also include a copy of their ID.

PLEASE SIGN ALL APPLICABLE STATEMENTS

☐ I attest that I have no income and have had no income from ____/____/____to ____/____/____

Signature of Patient/Guarantor	Signature Of Spouse/Other	Date

☐ I attest that I have no assets as listed on my Charity Care Application through myself or any other party. This also applies to any minor children in the household.

Signature of Patient/Guarantor	Signature Of Spouse/Other	Date

☐ I attest that I am homeless and have been homeless since ____/____/____

Signature of Patient/Guarantor	Signature Of Spouse/Other	Date

☐ I attest that I have no medical coverage through myself or any other party to cover the outstanding amount of this bill.

Signature of Patient/Guarantor	Signature Of Spouse/Other	Date

☐ I attest that I have not filed any income tax returns for the year(s) of _____ to _____.

Signature of Patient/Guarantor	Signature Of Spouse/Other	Date